AGY /SUB AGY	
EFF. DATE	MO/DAY/YR

State of Washington

Benefits Contribution Plan
Section 125 Waiver Form

- Type or print clearly in ink.
- Shaded areas are for agency use only.
- Check all copies.

SECTION 1: Subscriber Information

Social Security Number	Last Name	First Name	Middle Initial	Is This a Name Change? ☐ Yes ☐ No	Agency/Division Name

Home Mailing Address			
City		State	ZIP Code

County (residence)	Phone Number Home ( ) Work ( )	Date of Birth MO/DAY/YR	Current Agency Hire Date MO/DAY/YR

SECTION 2: Waiver of Insurance

I elect to waive the opportunity to participate in the state of Washington sponsored Benefits Contribution Plan authorized under Section 125 of the IRS code, or Section 125 Plan. I understand that by waiving participation in the Benefits Contribution Plan any premium I may be required to pay for the medical coverage I have selected will be deducted from my paycheck after all federal and/or state taxes have been collected.

_____ _____

Employee's Signature Date

HCA 50-185 (1/04)

Original to Payroll Office; Copy to Employee